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Clinical Section

The Changing Prognosis in Pulmonary Tuberculosis of Childhood*

By

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"The prognosis of tuberculosis in infancy is bad. We do not know of a single case which resulted in cure. Indeed there is not a positive instance where a tendency towards the limitation of the disease was observed." Thus wrote Schlossman in 1908. He was not alone in his pessimism, and even as recently as ten years ago few would have questioned his statement. A diagnosis of tuberculosis in an infant was equivalent to a death warrant.

There were several reasons why the outlook was viewed with such hopelessness. The diagnosis was usually made in children with advanced disease, who had been living in close contact with tuberculosis for some time and had not been brought to a doctor until they began to have "symptoms." As a result, the diagnosis was made in the child as it was made in the adult, when cough, night sweats, fever and loss of weight had made their appearance. The diagnosis was made late enough in adults; it was made even later in children. Little could be done. Meningitis or miliary tuberculosis soon closed the scene.

In recent years, examination by tuberculin and röntgen ray of all children exposed to open tuberculosis led to a new conception of childhood tuberculosis. The tuberculin test came into its own. At the beginning the test was received with enthusiasm and, as is often the case, too much was expected of it. When it was obvious that it could not prove everything or cure everything, it fell into disrepute. It was said that such a large portion of the population reacted positively to tuberculin it was of no value in diagnosis, but the pendulum has swung back again in recent years. We know now that there is a tremendous number of adults who have negative tuberculin tests, so that the proportion of children who do not react to tuberculin must be so large as to make the finding of a positive reaction an im-

portant clinical point. Only one-third of a recent class of nurses entering a large Minneapolis Hospital reacted positively to tuberculin. A great many medical students embarking on their careers react not at all to tuberculin. We must revise our old impressions. The tuberculosis campaign of the last twenty years, the building of sanatoria for open cases, the segregation of sputum—positive cases is having its effect. Great numbers of people are growing up who have not come into contact with the acid-fast bacillus and who therefore show a negative reaction to tuberculin.

The tuberculin test is of great value in finding unsuspected open tuberculosis as the following case summary will show. Two children, brother and sister, aged 6 and 8, were brought for examination because a distant relative who had never stayed in the same house with the children and had had no contact with them had died of tuberculosis. Tuberculin tests were done and to our surprise the girl showed a 3 plus reaction while the boy's was negative. The test was repeated with identical results. It was then learned that the girl was a favorite of her aunt's, visiting her frequently, while the boy, who was more than usually proficient in marking and destroying furniture, was not at all welcome, and visited his aunt rarely. This kind lady was found to have open tuberculosis. The case was complete. The girl no longer visits her aunt and at this date, two years since the diagnosis was made, has no active lesion in her lungs, although she has a healed one to show for her early visits.

The X-ray proved gross lesion in the lung to be far more common than was supposed, and to run a much more benign course. It became apparent that, if one wished to diagnose pulmonary tuberculosis in the early stages, symptoms were of little assistance and careful physical examination often of no assistance at all. The average child with early pulmonary disease was an apparently well child, more often overweight than underweight, with no anæmia, no night sweats, no tachycardia, no cough or expectoration and no pain in the chest. In fact the child with a cough was more often found to be non-tuberculous than tuberculous. Physical examination usually revealed nothing; occasionally an area of dullness and diminished breath sounds. Even after the presence of a lesion had been demonstrated by the X-ray film, physical signs often could not be elicited over this area.

The earlier and more frequent detection of pulmonary lesions in children which resulted from all this led to some interesting results. It became clear that length of exposure and prognosis were intimately related and that the most important point in treatment was the removal of the infected child from the source of infection. This source might be already known, in which

*From the Faculty of Medicine of the University of Manitoba and the Winnipeg Children's Hospital. This article embodies the results of work done by the authors at the Winnipeg Children's Hospital.

case that individual was segregated in a sanatorium or, if that did not prove to be practical, the child was removed to a hospital or preventorium. Very often the infecting source was not at once apparent and a diligent search of the home was the next and most obvious step. A carefully taken family history became of greater importance than a recital of symptoms or even a physical examination. The source was practically always found in the home; occasionally in the school-room or among associates. It was the father or the mother or the nurse or the boarder. Cod liver oil, sunshine, fresh air, hospitalization, rest in bed, all these were of minor importance compared with the most important therapeutic measure in childhood tuberculosis, the detection and removal of the infecting source.

Early diagnosis began to mean good prognosis.

When the child with pulmonary tuberculosis was found before signs or symptoms were apparent and was removed from the source of infection, it was soon learned, to the great surprise of pessimists of the old school and even to that of enthusiasts of the younger school, that a child could not only heal tuberculosis as well as an adult but often better. Large lesions involving a whole lobe of a lung would slowly melt away, and after a year or two only a few fibrous strands and a fleck or two of calcium would remain as evidence of the early infection. Prognosis instead of being bad was good, provided the infecting source was removed. If this were not done or if, after the child had healed his first infection, he were sent back to an infected household, the prognosis was bad. A child handles first infection with the tubercle bacillus very well; it handles second infection badly. The adult type of disease with cavitation makes its appearance and the child will frequently succumb.

The question then arose: Should these children be kept in hospitals or preventoria? At first they were, but now opinion is veering from this decision. Chester Stewart in Minneapolis goes so far as to say that children with primary lung lesions should be sent to school throughout the course of their disease. We do not agree with such a radical departure, mainly because we feel that we might thus be exposing other children to infection. But we do believe that children with primary tuberculous infection do much better at home than in hospital, provided that the infecting source has been removed. Keeping these children in hospitals or preventoria exposes them to the danger of intercurrent infection which often proves more serious than the original tuberculosis. In Minneapolis the only deaths occurred in the hospitalized group and in nearly every case from a cause unrelated to tuberculosis. It is our opinion that, provided the diagnosis is made early and the infecting source removed, the patient will do well if treated as an ambulant case. Periodic X-ray examination to determine the progress of the disease should be made, as in the rare case we have found that we have had to take more active measures. If they are again infected with

tuberculosis these children will probably do badly: they will handle their second infection not nearly as well as adults and the outlook will be grave.

The outlook in tuberculosis of childhood has swung half circle in the last decade. Prognosis has changed from bad to good. Whether it will hold steady there in the future depends upon the active realization by practitioners that *tuberculosis is an infectious disease, and that the physician's first duty to a tuberculous child is to prevent re-infection.*

*Imaginary Heart Disease

By

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In his monumental work on the heart Cabot makes the statement that most heart disease is imaginary. This is a difficult statement to prove, but we do know that with the marked increase in cardiac deaths (over 44% in the past 50 years) there is undoubtedly an increase in those unfortunate people who are fearful about their hearts.

It is the type of individual who has become "heart conscious" with whom we are concerned today. The threshold of symptoms varies with the individual. In any one person it may fluctuate with emotion or fear. In persons of leisure, imagination quickly outruns impairment of function and they come to our consulting rooms with a sound heart and many anxious enquiries.

It is well to remember that the words heart disease have a very sinister effect upon the lay mind. They suggest the dread pictures of angina and sudden death. This is particularly true in patients under 45. It is rare to encounter a cardiac neurosis after the age of 50. In fact it is often difficult to convince these older patients that their hearts are damaged.

The public ignorance and fear of heart disease reminds us of the history of tuberculosis. Not so many years ago a diagnosis or a suspicion of phthisis called forth terrific reactions in patients. Such a diagnosis meant death. Education and more accurate methods of diagnosis have dissipated the dread of this disease in the public mind. We rarely see a respiratory neurosis today. When we fully realize the very low percentage of sudden deaths in cardiac cases we will have less imaginary heart disease.

It seems wise to include all the synonyms of this type of disorder under one heading (Table I.) and define it as a syndrome with symptoms of a cardiac nature in persons with little or no evidence of organic heart disease.

*Abstract of paper read before Manitoba Medical Association, September, 1934.

Synonyms.

TABLE I.
IMAGINARY HEART DISEASE

1. Cardiac Neurosis.
2. Effort Syndrome.
3. Soldiers heart.
4. Neuro circulatory asthenia.
5. D. A. H.
6. Anxiety Neurosis (Cardiac).
7. Pseudo angina.
8. Functional Heart Disease.

The cause of imaginary heart disease is poorly understood but like most neuroses, the symptoms are aggravated by anxiety and fear.

It is not surprising that these neurotic individuals eventually have their fears directed to the heart. Whether or not they become chronic invalids depends largely upon the type of doctor they consult first. The exciting cause of a cardiac neurosis is often the physician; the physician who is not sure of himself. At the very first visit the doctor informs the patient that there is *probably* something wrong with the heart. The sounds are weak, or there is a "leaky valve" whatever that may be. Here it is often not the patient's heart which is weak, but the doctor's head. For some reason it seems almost impossible for many physicians to say the heart is normal and leave it at that. They add a word of caution to protect their reputation in case of accidents. This caution arouses doubt in the fearful patient's mind and the seed of a neurosis is sown.

The man who makes a heart examination should do one of three things: Tell the patient he *has* heart disease and give proper advice, tell the patient he has no heart disease, or if he doesn't know, call for the help of someone who does.

The most common cause of cardiac neurosis is the doctor who gives vague and doubtful opinions to those who come to him for advice about their hearts.

Another potent cause in the production of the syndrome is the insurance examination. One cannot estimate the mental anxiety of being refused life insurance. In an encounter with an insurance examiner there is no question as to who wins regardless of the incompetency of the examiner. It is not the applicant. Some of the refusals are due to (a) mortality statistics based upon incompetent examinations, (b) the persistent refusal of many insurance companies to consider the functional capacity of the heart muscle rather than cardiac murmurs as a basis for rating or rejection.

A third exciting cause of imaginary heart disease is the occurrence of sudden death in a close relative or friend.

It is interesting to know that no other group of psychoneurotics are more faithful to the medical profession. While they flit from pillar to post amongst us seeking re-assurance, they rarely consult quacks or treat themselves.

This very fact should stimulate our desire to help them and to treat them with the kindness and consideration they deserve.

In any case with cardiac symptoms at the onset we may find

- (a) A pure neurosis with a normal heart.
- (b) A diseased heart with normal function and a superimposed neurosis.
- (c) A normal heart responding to a pathological call.
- (d) A pathological heart with very early signs of malfunction and diminished reserves.

We are chiefly concerned with the first two groups. If we accept the accusation that the physician is responsible for many cases of cardiac neurosis, how can we avoid this pitfall? The answer is more accurate diagnosis.

The duty of the first physician to see a patient with cardiac symptoms is first to determine the presence or absence of real organic heart disease. There must be no compromise here. If organic disease is present, he must look for evidences of strain or diminishing cardiac reserve. We must estimate the reserve of the myocardium and here lies the whole crux of the situation in so far as the patient is concerned.

To illustrate these important points, let us review for those on the firing line of medicine the history of rheumatic infection, watching for the real evidences of organic lesions, the signs of diminishing function and some pitfalls in diagnosis.

You will note that we are discussing patients under the age of 45. Arteriosclerotic and hypertensive heart disease present entirely different problems.

The progress of Rheumatic Heart Disease may be conveniently divided into four stages: (1) The active stage or stage of invasion; (2) The stage of latent activity of infection; (3) The healed stage; (4) The stage of heart failure.

Acute Rheumatic infection is a disease involving all fibrous tissue including that of the brain, peritoneum pleura, joints, pericardium, heart valves and most important the myocardium. In children the joint symptoms are often transitory or absent. If acute rheumatism did not attack the heart it would be a disease of little clinical importance. However, after the acute symptoms are over, the infection lurks in the heart—often remaining active for many years.

Very often the onset of rheumatic carditis is insidious, much like some tuberculous infections. The importance of recognizing the signs of latent or insidious infection is obvious.

There is often a low grade fever persisting for many months, with general malaise, loss of weight and other symptoms of a mild infection. Careful study of the case will reveal a persistent tachycardia, either when awake or when under basal conditions. Shifting systolic murmurs may

be present, the typical rheumatic nodules may be seen and the most important sign of all — is a definite enlargement of the heart. Certain laboratory tests offer aid; a persistent leucocytosis or rapid sedimentation rate may be found. The treatment of course at this stage is *rest and rest* until all evidence of active infection has disappeared.

Stage of healing.

The tendency of all rheumatic infection is to heal, a process which may take months or years in the heart. In many instances healing takes place without obvious permanent damage. In others the valves contract and sclerose producing mitral or aortic lesions. Scar tissue is formed in the heart muscle itself or the pericardium becomes thickened or even calcified.

This is the stage of clinical signs *not* symptoms. There is often little functional impairment of the heart muscle, and such valvular or pericardial defects are quite compatible with normal and useful lives. We might compare this stage to the healed stage of pulmonary tuberculosis. We are all familiar with the clinical signs of mitral stenosis and aortic regurgitation and yet we still see such cases being ordered to bed for months and months although the heart muscle is quite able to bear the strain of ordinary life. More chronic invalids and neurotics are made by the stethoscope than by rheumatic heart disease.

There are certain positive signs here of value in the diagnosis of healed organic rheumatic lesions.

1. No or few real cardiac symptoms.
2. Cardiac enlargement.
3. Signs of aortic or pericardial disease.
4. Signs of mitral stenosis.
5. Auricular Fibrillation, Flutter or Heart block.
6. History of rheumatic infection.

You will notice that very little is said about murmurs. A diastolic murmur of course means heart disease, but usually there are other signs of aortic reflux or mitral stenosis which are of equal importance in the diagnosis. Once having diagnosed the organic disease we can forget the murmur and think about the functional capacity of the heart.

After years or months of reasonable capacity during the healed stage we come to the stage of diminishing cardiac function. Here symptoms become increasingly important, especially those related to exertion or effort. Many cardiac neurotics have complaints which simulate these symptoms.

Increasing breathlessness on exertion, or the development of a persistent tachycardia, are most important symptoms. As the reserve of the heart muscle is further diminished *symptoms* may occur

even at rest along with the characteristic *signs* of venous congestive heart failure, *i.e.*, increased venous pressure (neck veins) râles at the bases of the lungs, enlarged liver and finally oedema.

Certain symptoms are commonly found in imaginary heart disease. Of these, the most prominent are fear and anxiety. Such fear is often engendered by attacks of palpitation, by fainting or dizziness, by præcordial pain or dyspnoea not related to effort. Fear may be either the cause or the result of such symptoms. There are two striking features about these complaints. First, if organic disease is present the symptoms are out of all proportion to the amount of structural damage. Second, such symptoms are of little importance in a case of real heart disease with failing function. There are always others of much more significance.

Certain physical signs at times give rise to the fears of imaginary heart disease if brought to the patient's attention or unduly stressed by the physician. These are:

- Systolic murmurs.
- Extrasystoles.
- Paroxysmal Tachycardia.
- Sinus Arrhythmia.

Space will not permit a full discussion of the innocuous nature of these phenomena, but it will be noticed that in these cases the symptoms are many and severe, while the physical signs are few and inconsequent.

In dealing with these cases we are concerned chiefly with accurate diagnosis, and if there are no signs of organic heart disease and no symptoms of a failing heart, prompt and forceful reassurance at the first examination will do much to prevent the onset of a cardiac neurosis.

If the neurosis is well advanced, a very thorough examination with at times the use of special methods of examination may be necessary to reassure the patient. Repeated forceful reassurance often yields results. The abolition of certain disorders of rhythm such as Extrasystoles, and paroxysmal tachycardia by means of quinidine, etc., may remove the cause of the cardiac fear.

If time permits, an exhaustive investigation of the habits, emotions and childhood history of the constitutionally inferior types may be of value.

Finally, let us not either consciously or unconsciously sow the seeds of a neurosis by labelling harmless clinical findings as heart disease.

N.B.—A point stressed in the paper was the rarity of a cardiac neurosis in the older age groups, and that the criteria mentioned above for the diagnosis of organic lesions are quite different in cases of coronary or syphilitic heart disease.

*The Acute Abdomen in Children

By

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"A child is never too ill to despair of nor too well to be sure of." This is an old dictum which applies most aptly to the acute abdomen in childhood.

There is a great difference, both psychologically and physically, between acute abdominal diseases in the child and in the adult. Some of the unfavorable points in acute abdominal diseases of childhood are:

- (1) The peritoneum has been less vaccinated and is less resistant to general infection.
- (2) Lymph absorption is more vigorous and the momentum is relatively short and poorly developed.

But there is some compensation that the field of disease is narrowed and certain conditions common enough in the full grown are so rare that they can be excluded from general consideration in children, *e.g.*: Gastric and Duodenal Ulcer and Malignant Disease.

There is a more definite *age incidence* in the surgical pathology of the child. Certain ages suggest at once certain possible diseases. Appendicitis is extremely rare before the age of one year. Between four and sixteen months intussusception is very common. The sex of the child also may be suggestive. Intussusception, for instance, is more frequent in boys; Pneumonoecocol Peritonitis in girls. However, it is dangerous to attach too much importance to these preferences.

It is not the object of this paper to deal with all the catastrophes that may take place in the abdomen of children, but to discuss in a limited way some of the more common acute surgical conditions, such as acute appendicitis, with its complication, peritonitis; *primary* peritonitis, intussusception and congenital pyloric stenosis. The acute surgical conditions within the abdomen that occur during infancy and childhood must be looked on as extremely important when one considers the high mortality rate in cases in which the condition is incorrectly diagnosed, treatment by surgical measures delayed or the patient allowed to go untreated.

Nausea, vomiting of food, or bile stained mucous, crying on account of pain, visible peristalsis, abdominal rigidity, increased abdominal tension, an abdominal mass, decrease or absence of faecal stool, passing of bloody mucous from the bowel, should attract one's attention to the abdomen instantly, and an investigation should be made to determine whether or not an acute

surgical condition exists. An acute surgical condition within the abdomen quickly causes nutritive disturbances, toxæmia and death. Thus these conditions must be recognized early and appropriate treatment instituted at the earliest possible moment.

ACUTE APPENDICITIS

A study of acute appendicitis both early and late admitted to the surgical service of the Children's Hospital during the period of years 1926 to 1933, 286 cases in all, show that in two hundred cases operated on in which the diagnosis was made early and the inflammation was still confined to the appendix, there was not a single death.

Note then, that 86 cases out of 286 or 30% were admitted with complications such as ruptured appendix, abscessed or spreading peritonitis due to the delay of the parents in calling a physician, or due to the delay of the physician in making the diagnosis or in instituting surgical treatment. That there were 8 deaths or a mortality rate in this sub-group of 9.03% making the mortality rate in all cases of appendicitis 2.79%.

Appendicitis is the most common abdominal emergency met with in childhood. The fact that 30% of our cases presented with a ruptured appendix or other complication, goes to show that there is still much to be desired in the diagnosis and in educating the public that a pain in the stomach of a child is a serious condition and should not be treated with a dose of castor oil or Epsom salts.

DIAGNOSIS

In the diagnosis of appendicitis the history may be of great value. There may be remembered previous unexplained attacks of abdominal pain, or a recurring bilious habit.

During the acute attack the clinical features are:

1. *Pain*: The attack always begins with central or epigastric abdominal pain, later becoming localized in the right iliac regions. This is followed by

2. *Vomiting*: The more the appendix approaches the obstructive type the more vomiting is evident, but individuals vary greatly in the propensity to vomit.

3. *Tenderness and Rigidity*: Over the right iliac fossae is present.

4. *Temperature and Pulse*: Temperature and pulse in the early stage offer no clear guide. It is not until toxins are absorbed that the temperature and pulse may rise.

It is always a helpful guide to remember that pain precedes all other symptoms.

The above type of case is when the appendix lies in its normal position, but it may happen that the appendix lies in situations which bring it in contact with other organs and tissues, and where

*Clinical lecture read at Manitoba Medical College Post-Graduate Course, May, 1934.

if the appendix is inflamed sympathetic or secondary congestion of these organs or tissues may produce highly characteristic signs. Thus in the *Pelvic* appendix the proximity to the bladder and rectum may induce the special signs of painful and frequent micturition and diarrhoea and the pain will not necessarily be in the right iliac region. The *Retro-caecal* appendix may manifest itself by persistent flexion of the right hip. The *Messenteric* appendix may give rise to the signs of an acute intestinal obstruction. The *Sub-Hepatic* or *High* appendix — the presence of inflammation in this area may simulate diaphragmatic pleurisy. *Left Iliac Appendix* shows the ordinary features plus diarrhoea as a frequent symptom.

PROGNOSIS

The younger the child the more serious the prognosis. The position of the appendix, retro-caecal or mesenteric being the most dangerous types. Then, type of infection plays an important part, e.g.: Streptococcal, etc.

TREATMENT

It is agreed by all that the early acutely inflamed appendix should be removed at once. It is the writer's opinion that the expectant treatment of appendicitis is dangerous and should be discouraged.

What of the case of late appendicitis with abscess or spreading peritonitis? The teachings of Murphy are "that as soon as an appendix is diagnosed it should be operated upon, and the abscess or peritoneal cavity adequately drained." In the case of children, we are inclined to think that this applies to most cases; some we only drain, but if the appendix is easily accessible it is our practice to remove it. Gentleness and care are most essential here. If the child has been vomiting and dehydrated we give saline and glucose intravenously either interrupted or continuous. We may even give repeated small citrated blood transfusions.

Again, if an ileus is present we are now using the duodenal syphon or suction and are most pleased with the results in the cases treated thus far.

INTUSSUSCEPTION

Acute Intussusception is, after acute appendicitis, one of the most common causes of abdominal crisis in early childhood. The mortality rate in this disease is still very high, due mainly to the lateness in diagnosis. In reviewing the cases of acute intussusception operated upon at the Children's Hospital, it is found that in 39 cases there were 8 deaths, or a mortality rate of 23%. Statistics from the Sick Children's Hospital in Washington, U.S.A., gives the mortality rate as 30%. So it may be time well spent to review the symptoms, signs and methods of diagnosis.

CLINICAL FEATURES AND DIAGNOSIS

The symptoms are those of a sudden abdominal catastrophe, of the nature of acute intestinal obstruction. When we find a child, especially a

male child between the ages four to sixteen months, who has been previously healthy (and in the majority of cases, breast fed) — suddenly seized with severe abdominal pain, intussusception must be considered a possible cause. If blood is passed the possibility becomes a strong suspicion; if a tumor is palpable this becomes a certainty. But if no tumor is felt, one is quite justified in giving an anæsthetic to overcome the resistance of an unruly child. Again, digital examination may reveal some information not forthcoming otherwise. One may be able to feel the tumor or failing that, one may get the sensation of emptiness in the right iliac fossa. But more important is the absence of flatus and the possibility of blood or bloody mucous adhering to the gloved finger. Then if still doubtful a barium enema may be given and examined under the diascop. So the early distinguishing features of Intussusception are:

- (1) The sudden onset of violent intermittant pain, and vomiting in an otherwise well infant who may be breast fed and is usually male.
- (2) Passage of clear mucous stools streaked with blood. The absence of passage of flatus and faecal material and sudden distension of the abdomen are important.
- (3) The presence of a tumor.
- (4) Finally, when there is any doubt a Bismuth Enema should be given and a fluoroscopic examination made.

It is important to recall the fact that intussusception is the most frequent cause of obstruction in the young.

TREATMENT

The treatment is immediate operation. Pre-operative treatment — washing of the stomach, and saline, intravenously if necessary. Post-operative treatment — continuous intravenous or normal saline and 5% glucose if the child is greatly dehydrated, or blood transfusion. If the ileus is marked, duodenal syphon is useful.

CONGENITAL PYLORIC STENOSIS

Congenital Pyloric Stenosis is a disease characterized by:

- (1) Vomiting, projectile in character.
- (2) Progressive loss of weight. Progressive wasting.
- (3) Constipation.
- (4) Visible peristalsis.
- (5) Tumor.

Boys are more frequently affected than girls (10-1); and occurs more frequently in first borns and for some unknown reason is more prevalent in the summer months. Symptoms commonly appear about the second to fourth week, sometimes earlier, sometimes later. The important point in early treatment is to withhold weaning a male baby who commences to vomit shortly after birth to be sure that its condition is not one of pyloric stenosis.

In reviewing the cases of pyloric stenosis in our hospital from 1927 until 1933 there were 23 with five deaths or a mortality rate of 21.7%. It is my opinion that this high mortality rate is due to the fact that these cases are kept under medical treatment too long. We all know how these children continue to vomit, to lose weight, and the general condition becomes steadily worse. In delayed cases the surgeon when consulted, will possibly find a child in extremis, that is, greatly dehydrated, having lost anywhere from two to three pounds in weight, cold and clammy, and even cyanotic.

In some hospitals it is the custom to treat pyloric stenosis as an emergency; all are operated upon as soon as they are diagnosed. This, I believe, is the practice in the Babies' Hospital, New York. It is now the practice in the Sick Children's Hospital, Toronto, and I am told that in their last 300 cases of pyloric stenosis operated upon, there were no deaths.

Some of these children must have resuscitative measures, such as the administration of intravenous saline and glucose, or even blood transfusions, then operated upon as soon as possible. The Ramstedt is the operation of choice. The abdomen is opened by a right paramedian incision, the pylorus is delivered. The tumor is incised longitudinally from end to end, through the bloodless area above the level of the pyloric vein.

The treatment from then is dietetic. It is here that one appreciates the cases that have not been weaned as there is no food that compares with the mother's milk, but a great number have already been weaned thinking that the mother's milk did not agree with the baby.

PRIMARY PERITONITIS

We shall deal with pneumonococcal peritonitis:

- (1) A condition confined to female children.
- (2) Age period two to ten years.

This is possibly the most serious of all children's ailments; dramatic in its onset and dramatic in its finish.

CLINICAL FEATURES AND DIAGNOSIS

The disease may begin with an overwhelming suddenness, but more usually there are a few days of unexplained and indefinite malaise. There may have been some catarrhal signs, vomiting, diarrhœa, tenesmus, frequency and abdominal pain. Pain which is mostly pelvic as the disease frequently starts in the pelvic, having gained entrance by way of the female genitalia. The temperature is often high, higher than that associated with appendicitis. The pulse also raised. The face may be pallid, or again may be flushed with some cyanosis and the general appearance might suggest pneumonia. The abdomen soon becomes distended, and this distention is noted to lie below the umbilicus. The rigidity, when present, is of a different character; it is more doughy and less wooden. Diarrhœa is a very common symptom and has been present in all the cases which I have seen.

DIFFERENTIAL DIAGNOSIS

The diagnosis between pneumonococcal and streptococcal peritonitis is of minor importance for the same principles of treatment will apply to either of these forms of primary peritonitis, however, there is quite some difference in the prognosis as in Pneumonococcal we had a mortality rate of 50%, in streptococcal 100%.

It is a different matter when we come to consider the distinguishing features between pneumonococcal peritonitis and the peritonitis due to appendicitis. It is of utmost importance that this differentiation should be made as the treatment is entirely different. In advanced cases, it may be impossible on physical signs alone, but in the average case a critical examination of the history and the appearance of the patient goes a considerable way toward making a correct diagnosis.

In appendicitis in children the pain at the onset is always central, even when the appendix is concealed behind the cæcum or within the pelvis. At a later stage when the peritoneum is affected, there is always a hard rigidity, even when the abdomen has begun to be distended. Again, one can, in a great number of cases, show the maximum point of tenderness in the right iliac fossa where the appendix is situated.

If there is still some doubt a peritoneal puncture, *i.e.*, with skin incision, has been recommended as a diagnostic aid.

TREATMENT

To open the abdomen at the early stage of the disease is of no advantage; because there is no condition present which demands or is likely to be benefitted by drainage.

Delay sometimes raises embarrassment in case the peritonitis of appendicitis is confused with the pneumonococcal infection and for this reason the compromise is made of obtaining by abdominal puncture or by a more deliberate incision a sufficient quantity of the peritoneal fluid to afford bacteriological confirmation of the diagnosis.

It is our practice where the diagnosis is reasonably certain to delay operation until such time as the infection is sufficiently established and localized, a phase which is reached about the 12th or 14th day.

There are most important treatments which must be carried on during our expectant days:

- (1) Sufficient fluids for the body need must be supplied whether by mouth or saline and glucose by intravenous route.
- (2) Repeated small citrated blood transfusions.
- (3) The serum treatment—it must be along this line that we are to look for any improvement in our treatment of these conditions. There is considerable work being done on serums and there is now a rapid method of grouping the pneumonococcal organism and in this way the specific serum can be obtained much sooner. It is our hope that a more efficient serum will be at our disposal.
- (4) The duodenal syphon or suction again plays its part here in relieving the distension.

Medical Library University of Manitoba

A summary of the contents of some of the journals available for practitioners, submitted by the Faculty of Medicine of the University of Manitoba. Compiled by T. E. HOLLAND, B.Sc., M.D. (Man.), F.R.C.S. (Edin.).

"THE PRACTITIONER"—September, 1934.

This number contains a symposium on "The Relief of Pain," the following articles being of note:

"Headaches and Facial Neuralgia"—by Wilfred Harris, M.D., F.R.C.P.

"Earache and Its Treatment"—by John F. O'Malley, F.R.C.S.

"Dental Pain"—by Gerald Jack, M.C., M.R.C.S., L.R.C.P., L.D.S.

"The Treatment of Cardiac Pain"—by Arnold W. Stott, M.A., F.R.C.P.

"The Treatment of Pain in Lumbago and Sciatica"—by F. G. Thomson, M.A., M.D., F.R.C.P.

"Abdominal Pain: Its Significance and Treatment"—by Zachary Cope, M.S., F.R.C.S.

"The Causation and Treatment of Pelvic Pain in Women"—by Norman White, M.D., F.R.C.S., M.C.O.G.

"Foot Pain"—by John Fraser, M.C., M.D., Ch.M., F.R.C.S.E.

There is also an excellent article on "Criminal Abortion" by Frederick J. McCann, M.D., F.R.C.S., F.C.O.G.

† † † †

"THE CANADIAN MEDICAL ASSOCIATION JOURNAL"—October, 1934.

"Fractures of the Talus"—by A. Gibson, M.A., M.B., F.R.C.S. (Eng.), Winnipeg, and R. G. Inkster, M.D., Winnipeg.

—An excellent article dealing with the anatomical and clinical aspects as well as therapeutic measures. It is well illustrated by case histories and x-ray plates.

"A Study of the Relative Value of Cod Liver Oil, Viosterol and Irradiated Milk"—by T. G. H. Drake, M.B., F.R.C.P. (C.), Frederick F. Tisdall, M.D., F.R.C.P. (C.), and Alan Brown, M.D., F.R.C.P. (C.), Toronto.

—The Cod Liver Oil Series (137 babies) produced three rachitic babies, while none appeared in the Viosterol Series (186 babies) or in the Irradiated Milk Series (141) babies. Increasing the dose of either Cod Liver Oil or Viosterol did not produce a proportionately greater result.

"The Differential Diagnosis of Coma"—by George S. Young, Toronto.

"Common Duct Stone"—by R. V. B. Shier, M.B., F.R.C.S. (C.).

"Progressive Exophthalmos Following Thyroidectomy"—by H. A. Des Brisay, M.D., Vancouver.

"Bronchoscopy in the Diagnosis of Pulmonary Disease"—by Louis H. Clerf, M.D., Philadelphia.

"EDINBURGH MEDICAL JOURNAL"

"The Treatment of Pulmonary Tuberculosis by Artificial Pneumothorax and Other Methods of Collapse"—by

D. Melville Dunlop, B.A., M.D., F.R.C.P.E., and Bruce M. Dick, M.B., F.R.C.S.E.

—A very extensive article on the subject, well illustrated by radiograms.

"The Etiology of Leucorrhœa in the Virgin"—by R. Cruikshank, M.D., D.Ph., and A. Sharman, B.Sc., M.B., Ch.B., M.C.O.G., Edinburgh.

"The Tonsils, Their Function and Indications for Their Removal"—by L. W. Dean, M.D., St. Louis.

—The subject is well discussed.

"Antitoxin Versus No Antitoxin In Scarlet Fever"—by

Paschal F. Lucchesi, M.D., and

Jas. E. Bowman, M.D., both of Philadelphia.

—Administration of serum in the series of cases reported shows decrease in the number of febrile days and lower incidence of complications compared to a control series.

"The Secondary Case of Scarlet Fever"—by

A. L. Hoyne, M.D., and

J. H. Bailey, M.D., of Chicago.

† † † †

"THE JOURNAL OF THE AMERICAN MEDICAL ASSOCIATION"—Sept. 8th, 1934.

This number contains the following articles on "Encephalitis":

"Epidemiology of Epidemic Encephalitis"—by J. P. Leake, M.D., E. K. Mussin, M.D., and H. D. Chope, M.D., of St. Louis.

"The Symptoms and Diagnosis of Encephalitis"—by Theodore C. Hempelmann, M.D., St. Louis.

The J.A.M.A. of Sept. 15th, 1934, contains further papers which together with the above constitute a symposium on "Epidemic Encephalitis" with particular reference to the St. Louis epidemic of 1933.

† † † †

"THE AMERICAN JOURNAL OF THE MEDICAL SCIENCES"—October, 1934.

"Septicæmia"—by Fred Cadham, M.D., Professor of Bacteriology and Immunology, University of Manitoba.

—Dr. Cadham's method of treatment of Septicæmia by inoculation of a specific antiserum and transfusion of normal blood serum is described. A series of 100 unselected cases, covering a period of eight years, is recorded. The mortality rate is 10.5%. Cases recorded before this treatment was instituted showed a mortality of 85%.

† † † †

"THE NEW ENGLAND JOURNAL OF MEDICINE"—Sept. 6th, 1934.

"Studies in Agranulocytosis following the Use of Dinitrophenol"—by

William Dameshek, M.D., and

Samuel L. Gargill, M.D., Boston.

—One case was not recognized until the day before death. The other being diagnosed immediately upon the appearance of gingivitis, was successfully treated with adenine sulphate. Both patients had been taking dinitrophenol in the treatment of obesity.

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*"They shall not grow old, as we that are left grow old;
Age shall not weary them, nor the years condemn;
At the going down of the sun, and in the morning
We will remember them."*

Editorial and Special Articles

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Editorial

The Organization of the Canadian Medical Association in Comparison with the British Medical Association

During the discussions regarding the proposed amendments to the constitution and by-laws of the Canadian Medical Association, repeated reference has been made to the lines upon which the British Medical Association is organized. Reference to the B.M.A. Handbook and the Constitution and By-Laws of the Canadian Medical Association seems to indicate the chief difference between the two is that the British Medical Association is essentially a federation of the local medical societies, while the Canadian Medical Association is in practice only loosely associated with the Provincial Associations and the District Societies. These local societies are referred to as divisions and correspond roughly to our district medical societies, e.g., the Winnipeg Medical Society or the North-Western District Medical Society. For administration purposes these divisions are sometimes grouped into branches, which in some respects correspond to our provincial medical association, e.g., the Manitoba Medical Association. In considering the advisability of amending the constitution of the Canadian Medical Association on the lines of the British Medical, some allowance might have to be made for the difference in the political constitution of Canada. The division of the Dominion into provinces has no counterpart in the Old Country. It might be necessary for our provincial medical branches to be incorporated in each indi-

vidual province in order to deal with problems that would be affected by provincial autonomy. Further, in a country as large as Canada, it is impossible to maintain a governing body which is both a representative council and at the same time an efficient executive. A council, thoroughly representative, preferably elected by the provincial associations, familiar with the practical problems of each section of the country and instructed by the provincial body, and yet small enough to meet at sufficiently frequent intervals to carry on such business as may properly come within the sphere of the Canadian Medical Association, probably could work effectively if it used as its instrument for carrying out its policy a small permanent executive.

In the British Medical Association a single fee enables a member to belong to the whole organization, which would correspond to our district medical society, provincial medical association, and the Canadian Medical Association. Apparently the funds are controlled by a single office, but a certain proportion of these funds is allowed to each division and branch on the basis of their membership for the ordinary purposes of administration. A superficial examination of the constitution of the British Medical Association reveals the fact that the Association maintains numerous committees to deal with various problems of local and national importance, and apparently these problems are dealt with on the initiative of the association itself as a result of the association's sense of responsibility to the public, instead of waiting for representations to be made to the association.

In the discussion of the proposed amendments to the constitution of the Canadian Medical Association, it was suggested that a Field Secretary should be appointed in each province or in a group of provinces. It appears that the secretaries of the divisions and branches of the British Medical Association perform a similar function.

The council of the Canadian Medical Association have asked for suggestions from the Manitoba Medical Association with regard to the constitution and by-laws of the association. As will be noted in the minutes of the last Executive meeting, this problem was thoroughly discussed and a memorandum forwarded to the Canadian Medical Association. As this is a problem which affects every medical practitioner in the province, it is necessary that each man should make himself familiar with the question and possibly forward any suggestions to the Executive of the Manitoba Medical Association. C. W. MacC.

(Memorandum — Pages 16-17)

Report from the Committee on Sociology of the Manitoba Medical Association

A statement was made recently at a meeting of representatives of the great voluntary hospitals of England that applicants at the out-patient department must be sorted and classified. This sorting can be done in two ways, (a) in the out-patient department, and (b) by the family practitioner. The first is not economic because the members of the honorary staff are unwilling to carry out a rather tiresome routine, and the service must therefore be carried out by salaried employees of the hospital. If the classification is done by the private practitioner, it is found that eighty per cent. of the sick can be diagnosed and treated by him. The meeting appeared to be strongly in favor of a widespread use of the doctor's letter.

The Committee on Sociology is now trying to prepare a form to take the place of the doctor's letter; when the rough draft is prepared it will be submitted to representative members of the honorary staffs, superintendents and directors of hospitals and practitioners for further recommendations.

The filling up of the form must involve a minimum of clerical effort on the part of the practitioner; a statement should be included that the patient is, in the opinion of his doctor, entitled to the services of the honorary staff; there must also be a time-table and list of departments of the out-patient departments of all hospitals in Greater Winnipeg. Suggestions from the general body of practitioners will be welcome at any time. In the meantime, all doctors in practice are requested to keep in mind the need for teaching material; the co-operation which was asked for in a recent circular must not be allowed to flag.

May a relief case be sent by his doctor to an out-patient department for consultation, is a question which has been recently propounded. The answer is that consultation is rarely refused by medical referees when justified, and as city and municipal authorities will pay for such advice, it is unreasonable to expect an honorary staff to provide the service for nothing.

The relief formulary, prepared by the Druggists' Association with the assistance of the Committee on Sociology and the Civic Relief Committee, came into operation on October 15th. Copies, costing twenty-five cents, may be obtained at 101 Medical Arts Bldg. or at 981 Elgin Ave. In addition, the favourite prescriptions of many doctors, if compounded solely from B.P. or C.F. products, will be dispensed at a flat rate satisfactory to druggists and the Civic Relief Committee. Prescriptions of proprietary preparations must be authorized by presentation to the medical referee, and may be returned to the prescriber with a request to use a non-proprietary preparation approximately similar in composition.

It is acknowledged that the formulary is probably far from perfect, but it is not likely that it will be altered until a three months' trial has been made. Suggestions for improvements, if forwarded in writing to the Committee on Sociology, will be placed before the editors of the relief formulary. The success of this experiment is only possible through the co-operation of all practitioners.

Minutes of Meeting of Executive of Manitoba Medical Association

MINUTES of a meeting of the Retiring Executive and the Executive-Elect of the Manitoba Medical Association, held in the club-rooms of the Medical Arts Building, on Thursday, October 25th, 1934, at 6.30 p.m.

Present.

Dr. G. W. Rogers	— Chairman
Dr. J. C. McMillan	Dr. A. G. Meindl
Dr. F. W. Jackson	Dr. C. W. MacCharles
Dr. F. G. McGuinness	Dr. C. W. Wiebe
Dr. E. S. Moorhead	Dr. T. A. Pincock
Dr. J. D. Adamson	Dr. C. A. MacKenzie
Dr. F. D. McKenty	Dr. F. A. Benner
Dr. W. G. Campbell	Dr. J. M. Sigvaldason
Dr. A. F. Menzies	Dr. G. D. Shortreed
Dr. R. R. Swan	Dr. G. P. Armstrong
Dr. W. W. Musgrove	Dr. E. D. Hudson

Minutes of the last Executive meeting, held September 9th, 1934, were read by the Secretary and approved.

Dr. McMillan then introduced Dr. J. M. Sigvaldason of Shoal Lake, representing the North-Western District Medical Society. He then turned the business of the meeting over to the incoming Executive, thank-

ing the members for the assistance given him during his term of office. Dr. G. W. Rogers assumed the chair.

Recommendations from Secretary's Report. Re Charter.

Following discussion, it was moved by Dr. J. D. Adamson, seconded by Dr. C. A. MacKenzie: That the Secretary take the necessary steps to obtain a charter, but that the matter be investigated thoroughly before hand, and that draft of charter be submitted to the next meeting of the Executive for approval.

—Carried.

The suggestion was made that a sub-committee be formed to take this matter under advisement, particularly regarding the collection of fees and the standing of the Association with the College of Physicians and Surgeons should they become incorporated.

Dr. Campbell advised that there would be a meeting of the Council of the College within the next month, and that the matter of a union of the two bodies would be on the agenda.

The following committee was then appointed:

Dr. G. W. Rogers
Dr. F. D. McKenty
Dr. F. G. McGuinness
Dr. F. W. Jackson
Dr. J. D. Adamson.

Change in Fiscal Year.

It was moved by Dr. F. G. McGuinness, seconded by Dr. C. W. Wiebe: That the fiscal year of the Association be changed from that of December 31st to July 31st.

—Carried.

Revision of By-Laws of the C.M.A.

The Secretary read memorandum prepared by Dr. W. Harvey Smith, setting out the objects of the revision of the by-laws of the Canadian Medical Association, and criticisms in connection therewith. He advised that this report was in the hands of Drs. Musgrove and McKenty. (Copy on file).

Dr. Musgrove then addressed the meeting, stating that he had Dr. Smith's memorandum, but owing to the latter's absence from the City the committee had been handicapped in bringing in any definite recommendations, and had not had sufficient time to study the question thoroughly. He pointed out a number of matters which he considered needed revision. The constitution called for 130 members on the Council of the C.M.A. He named two or three members from Manitoba who were inactive practitioners. There were times, as men cannot be expected to travel from the Council, which, with ex-officio members, made a total of sixteen. Five constituted a quorum, and three out of these five may be paid officials of the Association. Dr. Musgrove, with permission, read several extracts from Dr. Moorhead's address at the meeting of the C.M.A. at Calgary last June.

Dr. McKenty stated that the matter was too important for any hasty decision. Criticisms of the C.M.A. had been made by the West, and he thought that, if possible, the date for submitting the recommendations should be postponed in order to give the matter due consideration. One point which Dr. J. S. McEachern, President of the C.M.A., had brought up was that the Executive should be selected from members within one night's journey from the City of Toronto, in order to provide an Executive that would readily function. The C.M.A. is a voluntary association, depending upon the moral support of its members. He suggested paying expenses of representatives, as men cannot be expected to travel from the extreme ends of the Dominion to attend Executive meetings in Toronto.

Dr. McMillan stated that, following the annual meeting in Winnipeg, another small meeting had been held with Dr. McEachern and Dr. Routley to discuss this subject. He read letter from Dr. McEachern,

under date of October 7th, and stated that, as the matter was of such importance, Dr. Routley should be advised that we cannot send definite recommendations in the time allotted.

Dr. Adamson stated that he was one member who had been on the Executive of the C.M.A. for a good many years and had attended quite a number of their meetings, and he could not agree with Dr. Musgrove's remarks. The Council of the C.M.A. was not a figurehead. If Manitoba was not represented, it was their own fault. Members are elected, but in a very perfunctory manner, and usually men are picked who expect to attend the meeting. He could see no reason why paid men should not run the Association. The constitution could probably be revamped, but it was a difficult matter to say in what way, as, if the provinces are not properly represented under the present arrangements, they are themselves to blame.

Dr. McMillan stated that he agreed with Dr. Adamson's remarks, but that it was impossible to get men from the provinces who were familiar with the Association's problems to go to these meetings unless their expenses were paid.

Dr. Swan asked why these meetings could not be held in a central place; the City of Winnipeg being approximately the centre of the Dominion might be more convenient than any other point.

Following further discussion, it was moved by Dr. A. F. Menzies, seconded by Dr. F. D. McKenty: That Drs. Moorhead, McMillan and Adamson be added to the committee, and that this matter be referred back to the committee, so that they may further study the question and report back to the Executive as soon as possible. —Carried.

The Secretary stated that he had just received a communication from Dr. Harvey Smith asking for recommendations so that he could bring them before the Council meeting of the C.M.A. on October 30th.

Dr. Moorhead suggested that one or two general suggestions be prepared and forwarded by night lettergram to Dr. Harvey Smith at once.

Dominion Council Examinations.

Letter was read from the College of Physicians and Surgeons, under date of October 25th, advising that the question of writing the Medical Council of Canada examinations in parts would be presented before the Medical Council of Canada again by their representatives.

Committee on Economics of the C.M.A.

Following remarks by the Secretary, it was moved by Dr. F. D. McKenty, seconded by Dr. F. A. Benner: That this matter be referred to the Committee on Sociology for their consideration and report. —Carried.

The Secretary stated that there was a letter to Dr. Grant Fleming in connection with this matter, which should also be referred to the Committee on Sociology.

Appointment of Committees for 1934-35.

It was duly moved and seconded that the following be appointed to act on committees for the 1934-35 season:

Hon. Advisory Committee to
Minister of Health & Public Welfare.

Dr. G. W. Rogers, Chairman
Dr. Ross Mitchell
Dr. G. S. Fahrni
Dr. J. D. McQueen
Dr. A. T. Mathers
Dr. C. W. Wiebe.

Representatives to C.M.A. Council.

Moved by Dr. E. D. Hudson, seconded by Dr. G. P. Armstrong: That the appointment of this committee be left with the President and Secretary, to be

selected at a later date, or as soon as they can ascertain who will be attending the C.M.A. Council meeting next year. —Carried.

(Dr. Rogers suggested that the Vice-President and the Secretary make this appointment).

Legislative Committee.

Dr. G. S. Fahrni, Chairman
Dr. C. R. Rice
Dr. W. W. Musgrove.

Radio Committee.

Dr. R. W. Richardson, Convener (with power to add).

Extra Mural Committee.

Dr. J. S. McInnes, Convener (with power to add).

Historical Medicine and Necrology.

Dr. Ross Mitchell, Convener (with power to add).

Maternal Mortality.

Dr. Lennox Arthur, Convener (with power to add).

Editorial Committee.

Dr. C. W. MacCharles, Convener (with power to add).

Editorial Board of C.M.A. Journal.

Dr. Ross Mitchell
Dr. E. S. Moorhead (with power to add).

Auditors.

Dr. A. J. Swan
Dr. D. C. Aikenhead.

Representative to Manitoba Sanatorium Board.

Dr. F. A. Benner.

Editorial Committee.

Dr. MacKenzie addressed the meeting and stated that, owing to the very considerable amount of work entailed in handling the "Review," he felt that an honorarium should be granted to the Editor for his services. He pointed out that the publication had been greatly improved and was now operating on a self-supporting basis, which was due to the efforts of the Editor.

Dr. McGuinness stated that he agreed with Dr. MacKenzie's remarks, and felt that the Editor's services should be recompensed.

It was moved by Dr. F. G. McGuinness, seconded by Dr. C. A. MacKenzie: That an honorarium be granted the Editor of the "Review" as soon as the Association's finances permit this. —Carried.

Re. 1935 Annual Meeting.

Minutes of a special meeting of the Executive, held September 13th, 1934, were read by the Secretary. This meeting had been called to discuss the invitation of the Ontario Medical Association to hold the 1935 annual meeting in conjunction with them at Fort William next May.

The Secretary reported on the returns to the questionnaire, which had been sent to all members of the Association, stating that a very large percentage of the replies were in favor of holding the meeting at Fort William.

Following discussion, it was moved by Dr. J. D. Adamson, seconded by Dr. R. R. Swan: That we accept the invitation of the Ontario Medical Association to hold a joint meeting with them at the Head of the Lakes next May, and that this Association supply one day of the scientific programme. —Carried.

Further, it was moved by Dr. J. C. McMillan, seconded by Dr. C. W. Wiebe: That the business meeting of this Association be held in the Fall at the time of the post-graduate course of the Medical College. —Carried.

Further, it was moved by Dr. F. A. Benner, seconded by Dr. C. A. MacKenzie: That Dr. F. G. McGuinness be appointed Convener of the Programme Committee, with power to add. —Carried.

Committee on Sociology.

Dr. Moorhead gave a short report on the work of the Committee on Sociology, and expressions of opinion were obtained from the country members present as to the difficulties in the various districts in obtaining agreements with the various councils.

Dr. Shortreed stated that in Gilbert Plains Municipality the attitude of the council was that of refusal to pay anything as they considered they were not legally bound to do so. In the Municipalities of Hillsburg and Boulton, the attitude was one of indifference. They would not do anything, hoping that nothing would be done before the expiration of the relief contract.

Dr. Rogers stated that in Dauphin the council would not commit themselves. They were also vying for time, and some three or four of the members were favorable, but others were not. Their problem consisted mainly of indigent cases, the relief in this vicinity being negligible.

Drs. Pincock and Wiebe spoke with reference to conditions in their districts. In the Municipality of Stanley, where Dr. Wiebe was located, they did not choose to press very strongly for payment of fees for relief cases. The Municipalities were doing considerable toxoid and preventive work, and the remuneration from this, he felt, was sufficient to offset what they might receive from relief.

Dr. McKenty stated that in small towns there was a certain number of chronic indigents. If the municipalities could be persuaded to pay for these cases, it might be of assistance.

Signing Officers.

Dr. McGuinness suggested, before putting this motion, that the Treasurer of the Association should, as one, sign all cheques and documents, together with any one of the following: President, Vice-President or Secretary.

Following discussion, it was moved by Dr. J. C. McMillan, seconded by Dr. F. D. McKenty: That Dr. F. G. McGuinness, Treasurer, together with any one of the following be authorized for and in the name of the Manitoba Medical Association to sign all cheques and documents:

Dr. G. W. Rogers, President.
Dr. F. D. McKenty, Vice-President.
Dr. F. W. Jackson, Secretary.

—Carried.

Interim Financial Report.

This report, having been read at the Annual Meeting, Dr. McGuinness stated that he had nothing to add other than a statement of the annual meeting expenses and entertainment, which showed a loss of some \$229.00.

Dr. Rogers stated that some concerted effort should be made to obtain more members. He suggested that, if he were furnished with a list of those who were not members in the country districts, he would write to each one personally. It was further suggested that the President draft a letter to be inserted in the "Review," appealing for membership. This is to be done.

Correspondence.

The Secretary read letter from Dr. G. F. Stephens, under date of October 5th, with reference to blood donors.

It was moved by Dr. J. D. Adamson, seconded by Dr. R. R. Swan: That we pass this on to Colonel Gillespie of the St. John Ambulance Association, stating that, as the Winnipeg General Hospital had al-

ready expressed their desire for such a service, they get in touch with the other hospitals. —Carried.

Letter was read from the College of Physicians and Surgeons, under date of October 25th, advising that the Council of the College had made a further grant to the Association of the sum of three hundred dollars (\$300.00) to carry on extra-mural post-graduate work.

This was received with much appreciation and it was moved by Dr. C. A. MacKenzie, seconded by Dr. F. G. McGuinness: That a vote of thanks be tendered to the College for this donation. —Carried.

Letter was read from Dr. T. C. Routley, under date of October 10th, quoting sections of the Act respecting Chiropractors in British Columbia, which had been passed by the Provincial Legislature last Spring. This was ordered filed.

Letter was read from the Waskada Board of Trade, under date of October 15th, asking this Association to use its influence in any way possible towards having a doctor located in that district. The Secretary was instructed to reply that we will do all possible to get a doctor to locate there, but that the Association is unable to finance any part of his expenses.

Letter was read from the College of Physicians and Surgeons, under date of October 25th, advising that the following had been appointed as their representatives to this Executive:—

Dr. W. G. Campbell
Dr. W. H. Secord
Dr. H. O. McDiarmid.

Letter was read from the College of Physicians and Surgeons, under date of October 25th, asking this Association to appoint three members to act on the Committee of Twelve for the year ending September 30th, 1935.

It was moved by Dr. J. D. Adamson, seconded by Dr. C. A. MacKenzie: That the Legislative Committee of the Association be the appointees from this Association to the Committee of Twelve. —Carried.

Letter was read from the College of Physicians and Surgeons, under date of October 25th, advising that the College would continue to pay the sum of fifteen dollars (\$15.00) per month towards the publication of the "Manitoba Medical Association Review." The Secretary was instructed to write to the College, thanking them for this contribution.

Letter was read from Dr. T. C. Routley, under date of October 2nd, in which was enclosed an extract from the editorial column of the Medical Press and Circular of London, England. This article was ordered filed.

The meeting then adjourned.

Report of Committee on the Constitution of the Canadian Medical Association

There is very good reason to believe that the integrity of the Canadian Medical Association has been threatened in recent years. The unanimity and cohesion that should form the backbone of a national organization seems to have become impaired. We believe that this tendency is to be deplored and feel that every effort should be made to consider it and to place the Canadian Medical Association in a strong position throughout the whole Dominion.

The reasons for this tendency to disintegration are, no doubt, complex, and possibly have an intimate relation to general economic conditions. These conditions we cannot hope to influence. We can, however, make a close scrutiny of our own organization with

the hope of discovering its defects and applying appropriate corrections. After such a scrutiny, we feel that the chief defect is that the contacts of the various provincial societies, with the parent body, are not as intimate nor as direct as they should be.

The Executive Committee of the Canadian Medical Association has very wide powers. It can, according to the Constitution, assume all the functions of the Council. In spite of this, it has no direct contact with, or responsibility to, the various provincial bodies. Its members carry no mandate from their provinces and need not report to them. At various times, certain provinces have been entirely without representation on the Executive for several consecutive years. Such a condition must tend to produce a state of indifference or even antagonism to the activities of the Executive in the outlying provinces.

The Council, as it is planned in the Constitution, is a thoroughly representative body; in practice it is not representative. Its members, so far as the Western Provinces are concerned, are usually those who can afford the time and money to attend the annual meeting, and not necessarily those who are best qualified to represent the provinces. The Council meetings consequently usually contain a large number of disinterested and irresponsible onlookers.

We feel that the Canadian Medical Association should in effect be a federation of the various provincial associations, and in order to implement this plan we make the following suggestions:

1. The Council: The Council shall be much smaller and more representative. It might consist of two or three accredited representatives from each province. This body shall direct the general policies of the Association. It could meet several times a year. Each provincial group would be expected to report the proceedings directly to its own Executive. This Council should directly control, and be responsible for, the activities of the Executive. The expenses of the members of the Council could be met by the Canadian Medical Association and the various provincial associations. The meetings of Council could be held at various places as occasion demands. Sectional or regional meetings might also be arranged, e.g., all the Maritime members of Council, together with the Secretary, President and Chairman of Council, might meet for a special reason.

Such a plan would no doubt involve a greater expense than the present plan. This outlay would, we think, be justified as a definite contribution to the consolidation of the Association. It would not be necessary that every member of Council should attend each meeting. Whether or not they should go could be determined by the various provincial executives after considering the agenda.

2. The Executive: The Executive should consist of a small centralized body whose function is to carry out the plans of the Council. It might be composed of the Secretary, Treasurer and Chairman of Council, together with the President and President-Elect as ex-officio members.

3. Annual General Business Meeting: This should occupy one day before each annual meeting. This should be open to all members. Some subjects of general interest should be introduced and freely discussed.

4. Field Secretaries: In order to further unify, it might be well for the Canadian Medical Association to have a Field Secretary in each province. He might be a part time Secretary, who would look after the interests of the Canadian Medical Association in the province (membership, etc.), and should be selected by the local Executive.

5. Branches or Divisions: The various provincial organizations might be designated as divisions of the Canadian Medical Association, and the district societies might be called branches. All proceedings of the parent body could be passed to divisions and branches.

These suggestions are intended to be remedial rather than radical. We submit them with a sincere interest in the future of the Canadian Medical Association, and with the hope for its perpetuation and strength.

Members of Committee:—

W. HARVEY SMITH
F. D. McKENTY
J. C. McMILLAN
E. S. MOORHEAD
W. W. MUSGROVE
J. D. ADAMSON.

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NOTICE

CANCER RELIEF AND RESEARCH INSTITUTE

Physicians are reminded that the Cancer Relief and Research Institute furnishes a tissue diagnostic service. Specimens of tissue for pathological examinations should be forwarded to: D. Nicholson, M.D., M.R.C.P., Cancer Relief and Research Institute, Medical College, Winnipeg.

CLINICAL MEETINGS

At Brandon General Hospital
2nd Wednesday at 12.30 p.m.

At Brandon Hospital for Mental Diseases
Last Thursday. Supper at 6.30 p.m.
Clinical Session at 7.30 p.m.

At Children's Hospital
1st Wednesday.
Luncheon at 12.30 noon.
Ward Rounds 11.30 a.m. each Thursday.

At Grace Hospital
3rd Tuesday.
Luncheon at 12.30 p.m.
Discussion of Obstetrical Cases will form a large part of the clinical hour.

At Misericordia Hospital
2nd Tuesday at 12.30 p.m.

At St. Boniface Hospital
2nd and 4th Thursdays.
Luncheon at 12.30. Meeting at 1.00 p.m.
Ward Rounds 11.00 a.m. each Tuesday.

At St. Joseph's Hospital
4th Tuesday.
Luncheon at 12.30. Clinical Session 1.00 to 2.00 p.m.

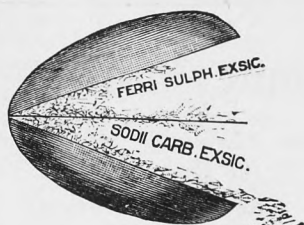
At Victoria Hospital
4th Friday.
Luncheon at 12.00. Meeting at 1.00 p.m.

At Winnipeg General Hospital
1st and 3rd Thursdays.
Luncheon at 12.30. Clinical Session 1.00 to 2.00 p.m.
Ward Rounds 10.00 a.m. each Thursday.
Pathological Conference at Medical College at 9.00 a.m. Saturday during College Term.

Winnipeg Medical Society
3rd Friday, Medical College, 8.15 p.m.
Session: September to May.

Eye, Ear, and Throat Section
1st Monday at 8.15 p.m., at 101 Medical Arts Bldg.

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Department of Health and Public Welfare

NEWS ITEMS

RADIO TALKS: For the past four years a series of health talks have been broadcast over Station CKY in Winnipeg, during the winter months, by the Department of Health and Public Welfare. The fifth programme began on October 16th, 1934, and will continue every Tuesday and Friday thereafter until the end of April, 1935.

As we believe that these talks are of interest to every citizen, we would appreciate it if all medical men practising in the Province would take every opportunity of informing his patients and friends of the time and Station through which they may hear the Radio Talks from this Department, on Tuesday and Friday at 4.30 p.m., and on alternate Wednesdays at 12.30 p.m.

The subjects for each month are being arranged as follows:—

WEDNESDAYS at 12.30 p.m., and

TUESDAYS at 4.30 p.m.

October	“Present Health Problems”
November	} “Changing Health Needs”
December	
January	} “Mr. Average Citizen Wants to Know”
February	
March	

Note—A dramatic series in which Mr. Average Citizen visits health agencies in Manitoba to find out their purpose and work.

April	“Health and Public Welfare Needs in Manitoba”
-------	---

FRIDAYS at 4.30 p.m.

October	} “Child Health Problems”
November	
December	
January	“What Women’s Organizations are Doing for Health”

Note—A dramatic series in which a representative of a Woman’s Club visits Officers of Women’s Organizations to find out what they are doing to promote better health.

February	} “My Body and How it Works”
March	
April	

Note—A series of stories for older children to supplement school lessons in physiology and hygiene.

Under the above general headings the following Radio Talks will be given:—

TUESDAYS at 4.30 p.m., and

Alternate WEDNESDAYS at 12.30 p.m.

October, 1934.

- (T) 16—Introduction by the Minister of Health and Public Welfare.

Present Health Problems

- (T) 23—Health Insurance for the Winter.
(T) 30—Better Health for the Family.

November.

- (T) 6—Everybody’s Business.

Changing Health Needs

- (W) 14—Diet and Health.
(T) 20—Leisure and Health.
(W) 28—Noise and Health.

December.

- (T) 4—Economy and Health.
(W) 12—Habits and Health.
(T) 18—Middle Age and Health.

January, 1935.

- (W) 9—A Health Message for the New Year.

Mr. Average Citizen Wants to Know

(Mr. Average Citizen visits health agencies to find out their purpose and work)

- (T) 15—Sanatorium Board.
(W) 23—Cancer Relief & Research Institute.
(T) 29—Winnipeg Health Department.

February.

- (W) 6—Municipal Health Unit.
(T) 12—Manitoba Division of the Canadian Red Cross Society.
(W) 20—Department of Health and Public Welfare—Vital Statistics.
(T) 26—Hospital for Mental Diseases.

March.

- (W) 6—Disease Prevention.
(T) 12—Hospitalization.
(W) 20—Public Institutions and Relief.
(T) 26—Child Welfare.

April.

- (W) 3—Child Welfare.
(T) 9—Does Health Work Pay?
(W) 17—Health and Social Workers Save Taxpayers.
(T) 23—Public Health Needs in Manitoba.

May.

- (W) 1—The Child’s Heritage—Health and Happiness.

FRIDAYS at 4.30 p.m.

Child Health Problems

October, 1934.

- 19—Most Blindness in Children is Preventable.
26—Baby Teeth and Their Care.

November.

- 2—The Child Who Takes Cold.
9—Symptoms of Illness.
16—Public Health Nursing for Healthy Childhood.
23—Tonsils and Adenoids.
30—Safeguarding the Child Against Communicable Disease.

December.

- 7—Sanitation in Relation to Child Health.
14—Food Protection in Relation to Child Health.
21—Mental Hygiene and the Child.
28—Mental Hygiene and the Child.

January, 1935.

- 4—Grandmother’s Spirit Returns.
(Comparison of Old and New Ideas).

What Women’s Organizations Are Doing for Health

January.

- 11—Local Council of Women.
18—Women’s Institutes.
25—Women’s Section of United Farmers of Manitoba.

My Body and How It Works

February.

(Stories for Children adapted with permission of the authors, Dr. W. W. Peters, Dr. O. Reisse, Mrs. D. W. Baruch, and publisher Harper and Brother.

- 1—The Legend of the Great East Gate.
- 8—Going from the Inside In.
- 15—The Parts that You See All the Time.
- 22—What Happens When You Eat.

March.

- 1—What Happens When Your Heart Beats.
- 8—What Happens When You Breathe.
- 15—What Would Happen if You Had No Bones.
- 22—What Happens When You Move.
- 29—What Happens When You See Things and When You Hear Things.

April.

- 5—What Happens When You Do Things.
- 12—Tasting and Smelling.
- 19—Mysterious Fluids.
- 26—As You Go On Living.

OPENING ADDRESS for the 1934-35 Series of Radio

Talks: The opening address was presented by the Honourable Mr. R. A. Hoey, Minister of Health and Public Welfare, on Tuesday, October 16th, and because it gives a synopsis of the work we are endeavouring to accomplish in Public Health through the medium of the Radio, we are publishing herewith a verbatim copy:—

“Ladies and Gentlemen:—

For the past four years a series of health talks have been broadcast by the Department of Health and Public Welfare. These talks have been delivered twice a week throughout the winter season.

This service has been made possible through the courtesy of Station CKY, for the purpose of broadcasting information regarding the problems of maternal and child health, communicable disease, sanitation, child welfare, and mental health. As a result, a great number of citizens in the Province of Manitoba, and many outside the Province, have received reliable health information.

For three years copies of these health messages were prepared and sent to individuals, who had made a special request for them. You may be interested to know that approximately 20,000 of these messages have been sent out from the Department. Through this means we discovered the great importance of the radio as a means for disseminating health knowledge, especially among those far removed from regular health services. It is worthy of mention that these copies of radio talks have been used in the study of health and social questions by community groups, as well as for reference reading by students in educational institutions. These facts indicate their value as an aid in promoting study and discussion in questions relating to health and community betterment. For this and other reasons, our radio program has been carefully planned each year so that some part of it would be helpful to everyone—old and young.

During the winter of 1930-31, there were 34 talks given and each year the number has increased until last year there were 55 broadcasts given by officers of the Department and others prominent in health service. All of these speakers were men and women of proven ability whose work it is to meet the particular problems dealt with in their talks.

The fifth year's program begins to-day, and will continue every Tuesday and Friday from now until the end of April, 1935. During October, November and December, on Tuesdays, there will be a series of talks on “Present Health Problems” and “Our Changing Health Needs,” which ought to prove helpful to all concerned in conserving health and strength during these difficult times in which we are living.

On Fridays, during these months, there will be a series on the “Health of Children,” designed particularly for parents and for all who undertake the care of children.

In January, on Tuesdays, and continuing until the end of March, there will be a dramatic series in which Mr. Average Citizen visits the chief health agencies in the Province to find out what they are doing for the people of Manitoba. These will be followed in April by a discussion of health matters of particular interest to tax payers. On Fridays, during January, there will also be a dramatic series to find out what women's organizations are doing to promote better health. These will be followed in February, March and April by health instruction in story form for older children to supplement the health lessons received at school.

We look upon our program of this year as the best balanced and the most worthwhile that has yet been arranged. There are a great many areas in our Province, the people of which experience the utmost difficulty in obtaining regular medical service. It is our hope that the people of these districts will be in a position to take full advantage of these lectures. We have always been, of course, interested in disease prevention. I have before me a pamphlet published by the Canadian Social Hygiene Council of Toronto, which contains a great deal of interesting information in respect to this problem. The statement is made that one person out of three dies ahead of time of diseases which could be prevented. Professor Winslow, of Yale University, states that 29% of all deaths in the United States Registration Area are postponable. An analysis of Ontario statistics would indicate that the average in that Province is higher—that 34% of all deaths are postponable. That is slightly over one in three.

Canadian statistics dealing with sickness indicate that over half of all disabling illness could be prevented. Estimates show that from two to three per cent. of the population is continuously on the sick list. Of these, between 91 per cent. and 96 per cent. are ill enough to be disabled. So that it can be said conservatively 2 per cent. of our population is always too sick to work. Two per cent. of the population is 180,000 persons, a very serious and expensive and dangerous sick list.

Public Health Officials agree that sickness costs the people of Canada over 311 million dollars a year. This does not take into account the loss in the actual earnings of the sick and physically incapacitated.

Every Tuesday at 4.30 and every Friday at 4.30, a health message will reach you from this Station. It is our hope this message will be helpful to you. If this service, however, is to serve our people in the sense that we want it to serve them, we must have comments and suggestions and questions from those who are listening in from time to time. You might address your communication either to Station CKY, Winnipeg, or to the Department of Health and Public Welfare.

I thank you.”

COMMUNICABLE DISEASES REPORTED

Urban and Rural : September, 1934

Occurring in the Municipalities of:—

Whooping Cough: Total 414—(Late Reported: Harrison for February-May inclusive 232, June 50, July 50, August 18; Pipestone: August 45; Stanley: June 2; Killarney: June 1; Morris: June 1); Brandon 5, Eriksdale 1, Wawanesa 1, Winnipeg 7.

Scarlet Fever: Total 74—Winnipeg 21, Woodlands 10, Stonewall 8, Unorganized 9, Harrison 5, Rosser 5, Rockwood 3, Roland 2, St. Andrews 2, St. Vital 2, Eriksdale 1, Fort Garry 1, Grandview Town 1, Springfield 1, Strathclair 1. (Late reported for June: Rockwood 1; for August: Rosser 1).

Measles: Total 73 — Boulton 11, The Pas 6, Shellmouth 5, Hanover 4, Silver Creek 3, Winnipeg 3, Gimli V. 2, Rockwood 2, Shoal Lake 2, Strathclair 2, Brandon 1, Dauphin T. 1, Kildonan East 1, Minto 1, Pipestone 1, Unorganized 1. (Late reported, June: Unorganized 23; July: Unorganized 2; August, The Pas: 2).

Tuberculosis: Total 69—Winnipeg 10, Unorganized 7, St. Boniface 5, St. Vital 5, Bifrost 2, Grey 2, Hanover 2, Kildonan West 2, Killarney 2, Portage la Prairie City 2, Rockwood 2, Souris T. 2, Springfield 2, St. James 2, St. Laurent 2, Clanwilliam 1, Daly 1, Desalaberry 1, Eriksdale 1, Gimli R. 1, Hillsburg 1, LaBroquerie 1, Lac du Bonnet 1, Minnetonas 1, Morris 1, Pipestone 1, Pembina 1, Portage la Prairie R. 1, Roland 1, St. Paul 1, The Pas 1, Tuxedo 1, Westbourne 1, Whitehead 1, St. Clements 1.

Chickenpox: Total 54—Winnipeg 41, Fort Garry 8, Hanover 2, Whitemouth 2, Kildonan E. 1.

Diphtheria: Total 24 — Winnipeg 8, Stanley 4, Unorganized 4, Hanover 3, Rhineland 2, Dauphin T. 1, Kildonan West 1, Tuxedo 1.

Typhoid Fever: Total 10—Westbourne 5, Brandon 1, Unorganized 1, Winnipeg 1. (Late reported, August: Langford 2).

Influenza: Total 8—Gimli Village 1. (Late reported, June: Grandview T. 2, Bifrost 1, Franklin 1, Grandview R. 1, Mossey River 1, Swan River R. 1).

Mumps: Total 7—Winnipeg 3, Unorganized 2, Minto 1, St. Boniface 1.

Erysipelas: Total 6—Winnipeg 3, Portage la Prairie R. 1, St. Vital 1, Stonewall 1.

Anterior Poliomyelitis: Total 2—Winnipeg 1, Rosedale 1.

Smallpox: Total 1—Unorgan. 1.

German Measles: Total 1 — St. James 1.

Typhoid Carriers: Total 1—Brandon 1.

Gonorrhoea: Total 77.

Syphilis: Total 35.

DEATHS FROM ALL CAUSES IN MANITOBA

for Month of July : 1934

URBAN—Cancer 35, Pneumonia (all forms) 14, Tuberculosis 13, Puerperal 3, other causes under one year 5, all other causes 111, Stillbirths 16. Total: 197.

RURAL—Cancer 18, Pneumonia (all forms) 14, Tuberculosis 12, Measles 1, Typhoid Fever 1, other causes under one year 4, all other causes 117, Stillbirths 13. Total: 180.

INDIANS—Tuberculosis 7, Pneumonia 1, Whooping Cough 1, other causes under one year 2, all other causes 3. Total: 14.

Winnipeg Medical Society

The regular monthly meeting of the Winnipeg Medical Society was held in the Physiology Lecture Theatre of the Medical College at 8.15 p.m. on Friday, October 19th. Two papers were presented:

“Recent Clinical Advances in Endocrinology,”
by Dr. A. Hollenberg.

“Trichomonis Vaginalis,” by Dr. E. W. Stewart.

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News --- Notes --- Correspondence

College of Physicians and Surgeons of Manitoba

The Forty-Ninth Annual Meeting of the Council of the College of Physicians and Surgeons of Manitoba was held in the Manitoba Medical College, Winnipeg, at 2.00 o'clock p.m. on Wednesday, October 17, 1934.

The following committees were appointed:—

Registration.

Dr. W. G. Campbell
Dr. L. D. Collin
Dr. T. Digby Wheeler

Finance.

Dr. W. H. Secord
Dr. W. H. Rennie
Dr. W. J. Harrington

Education.

Dr. C. W. MacCharles
Dr. W. H. Secord
Dr. C. C. Everson
Dr. W. F. Stevenson

Discipline.

Dr. R. J. Campbell
Dr. S. Bardal
Dr. A. E. McGavin
Dr. D. G. Ross
Dr. C. W. Burns

Taxing.

Dr. D. G. Ross
Dr. W. H. Secord
Dr. W. J. Harrington

Legislative.

Dr. J. S. Poole
Dr. H. O. McDiarmid
Dr. W. G. Campbell
Dr. C. W. MacCharles
Dr. W. H. Secord
Dr. D. G. Ross

Executive.

Dr. Wm. Turnbull
Dr. W. H. Rennie
Dr. W. G. Campbell
Dr. L. D. Collin
Dr. J. S. McInnis
Dr. H. O. McDiarmid
Dr. C. W. Burns

‡ ‡ ‡ ‡

During the past summer, the Council of the College of Physicians and Surgeons of Ontario removed a Doctor's name from the Register, after it had been proven that he was guilty of "infamous and disgraceful conduct in a professional respect." The nature of the offence with which he was so charged consisted in his engaging in newspaper advertising.

The Doctor subsequently brought the case before The Court of Appeal of Ontario; at which the action of the College of Physicians and Surgeons of June 27th, was upheld.

The Chief Justices in reviewing the case commented on the advertising as "most disgraceful."

OBITUARY

DR. STEPHAN STEPHANSSON

Dr. Stephan Stephansson of The Pas, Man., died in the Winnipeg General Hospital on Sept. 8th. He was born in West Selkirk, Man., in 1886, the son of Stephan Bjornson, a pioneer of that district. He graduated in medicine from Manitoba Medical College in 1912 and engaged in private practise until 1919 when he entered into partnership with Dr. Robt. D. Orok of The Pas, and with him was put in charge of all medical work in connection with the Hudson's Bay and Flin Flon Railways. When the Flin Flon medical service was organized in 1929 Dr. Stephansson entered it along with three other doctors. He remained in practice at The Pas until 1933, when he went to Flin Flon. He was a staunch Liberal, was president of the Liberal Association at The Pas and in 1927 was an unsuccessful candidate for the Manitoba Legislature. On July 23rd of this year he was stricken with acute appendicitis and Dr. B. J. Brandson of Winnipeg, went by air to Flin Flon in consultation. Two weeks later Dr. Stephansson was brought by plane to the Winnipeg General Hospital. He is survived by his widow and two sons.

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DR. HUGH MacKAY

After a prolonged illness Dr. Hugh MacKay died at his home on October 12th in his seventieth year. Dr. MacKay was born at Emro, Ontario; graduated in medicine from the Manitoba Medical College in 1895 and practised for some years at Carberry before removing to Winnipeg. He was one of the first practitioners of that city to employ radium as a therapeutic agent, and his knowledge of skin diseases lead him to be appointed Professor of Dermatology. He was a member of the honorary staff of the Winnipeg General Hospital and a member of St. Stephen's-Broadway United Church. He is survived by his widow and one son. Dr. James A. MacKay of Vancouver, is a brother.

Dr. MacKay was a man of much kindness of heart and integrity of life.

‡ ‡ ‡ ‡

DR. WILLIAM WEBSTER

The dean of Western Canadian anæsthetists, Dr. William Webster, died on October 23rd at the Winnipeg General Hospital as a result of inhaling gas fumes while extinguishing a fire in his cabin cruiser. Born August 24th, 1865, in Manchester, he came to Manitoba in the 90's, taught school in Winnipeg and graduated from Manitoba Medical College in 1895. He began as a general practitioner but soon became the first specialist in anæsthesia west of the great lakes. Possessing iron nerve, a keen mechanical sense and a passion for research, he had the ideal temperament for an anæsthetist. In 1902 he became anæsthetist to the Winnipeg General Hospital, a post held to the day of his death save for a break of four years of war service. In 1920 he became vice-president of the Canadian Society of Anæsthetists, and in 1922 president of that body. Two years later his book, "*The Science and Art of Anaesthesia*," St. Louis, C. V. Mosby Co., appeared.

Because Dr. Webster had taken active part in the Canadian Militia before 1914 it was no surprise when at the outbreak of the war he was given command of No. 4 Canadian Field Ambulance. In France his fearlessness under fire and his capacity for administration won him the Distinguished Service Order. Later he was commanding officer of the Convalescent Hospital at Uxbridge, then of No. 12 Canadian Hospital at Bramshott, and finally D.M.S. of Military District No. 10 at Winnipeg.

He was a crack revolver shot, one of the earliest motorists in Winnipeg and first president of the Winnipeg Automobile Club, but his real hobby was his motor launch in which he spent his holidays touring Lake Winnipeg.

His writings included his book and a number of papers on various phases of anæsthesia contributed to the *British Medical Journal*, *Surgery, Gynecology and Obstetrics*, *The American Journal of Surgery*, *Canada Lancet*, and the *Transactions of the British Association for the Advancement of Science*.

His greatest contribution to medicine, however, was his ability to teach the generation of medical students who came under his instruction at the Winnipeg General Hospital from 1902 to 1934 not only the A.B.C. of anæsthesia, but to instil in them something of his own imperturbability, his constant watchfulness and his resource. In 1919 his ability was recognized by promotion to be Associate Professor of Surgery (Anæsthetics) in the Faculty of Medicine of the University of Manitoba.

His widow, two sons and a daughter survive him.

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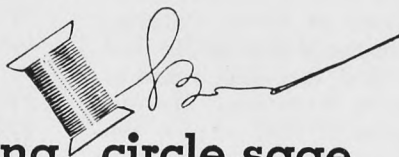
Surgical Department

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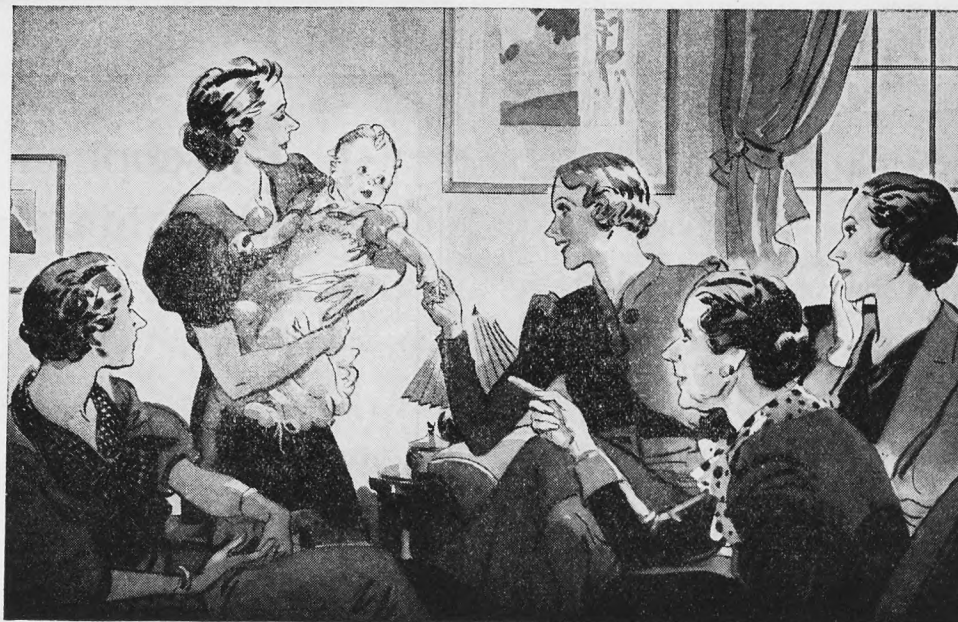
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Relative Values of Carbohydrates Employed in Infant Feeding

Continued down from 1911

1916

"For the addition of sugar, I usually use dextrin-maltose, which does not easily cause fermentation."—*L. L. Meininger: Use of Eiweissmilch, Arch. Pediat., 33:529-532, July, 1916.*

1916

In the treatment of marasmus, "Three per cent of malt sugar should be administered from the first, afterwards running up to as high a per cent as the child will take."—*L. T. Royster: A Handbook of Infant Feeding, C. V. Mosby Co., St. Louis, 1916, p. 100.*

1916

"Least irritating of all sugars, and more readily digested and quickly absorbed, is maltose."—*H. Lowenburg: A Practical Treatise on Infant Feeding and Allied Topics, F. A. Davis Co., Phila., 1916, p. 73.*

1916

"Dextrin-maltose is valuable in cases where intestinal disturbances are due to fermentation of milk sugar."

"Treatment (of sugar intoxication) consists in eliminating the latter (whey salts) as well as the sugars from the diet temporarily, and when the symptoms have subsided, a different sugar in proper proportion should be cautiously added; maltose and dextrin are preferable, because they are not apt to produce fermentation, while milk sugar is prone to set up fever and diarrhea."—*E. E. Graham: Diseases of Children, Lea & Febiger, Phila., 1916, pp. 179-201.*

1917

"For children who are not gaining on a normal formula with a sufficient amount of sugar of milk, or children who vomit when sugar of milk is fed, or who are constipated, the use of maltose instead of lactose often gives most satisfactory results. This is readily accomplished by substituting for the 4 or 5 per cent. of added sugar of milk an equal amount of dextrin-maltose or malted milk, which latter gives, in addition to the maltose, some protein food and an insignificant amount of fat. In many cases children who have failed to gain on other food will immediately show a marked gain as soon as this change is made."—*R. G. Freeman: Elements of Pediatrics, Macmillan Co., New York, 1917, pp. 191 and 192.*

1917

"The carbohydrates most used in infant feeding are the three soluble sugars and starch. The three soluble sugars are lactose, or milk sugar, maltose, or malt sugar, and saccharose, or cane sugar. Maltose is not used in its pure form, on account of its cost. The various commercial preparations of maltose are combinations of maltose with various dextrans, but as in digestion dextrin is converted into maltose, the chemistry is practically the same."

"The sugar which is not absorbed is broken down by the bacteria of the intestine into a great variety of fermentation products, among them being lactic, butyric, acetic, and succinic acids."

"Another effect of the excessive fermentation which results from a relative excess of carbohydrate in the food, is the formation of an excessive amount of gas. This may cause abdominal distention, and, extending backward, it may carry irritating acid products into the stomach, and thus cause vomiting."

"Lactose is the sugar most likely to produce acute symptoms. The stools are practically always green and very irritating. Flatulence and colic are less prominent."

"The maltose-dextrin preparations rarely produce acute exacerbations."—*C. H. Dunn: The Hygienic and Medical Treatment of Children, Southworth Co., Troy, New York, 1917, pp. 423, 424, 425, 428.*

1918

"The sugars in the foods are milk sugar which is found in mother's milk as well as in cow's milk, cane sugar and malt sugar. Though milk sugar is a natural ingredient of milk it is not well borne by babies when added to their food; they digest cane sugar, the ordinary granulated sugar, much better; malt sugar is the easiest digested by babies."—*C. G. Leo-Wolf: Nursing in Diseases of Children, C. V. Mosby Co., St. Louis, 1918, p. 24.*

1918

"Maltose (malt sugar) has the advantage of being very easily digested; when part of the sugar given is maltose, many children gain more rapidly in weight than when only milk sugar or cane sugar is used."—*L. E. Holt: The Care and Feeding of Children, D. Appleton & Co., New York, 1918, p. 66.*

1919

"In the administration of protein milk with its large protein content, by adding to it sugar which is not easily fermented (dextrin-

maltose), we produce, instead of pathologic fermentation, a condition of putrefaction which changes the acidity of the intestinal contents to alkalinity, the peristalsis is decreased, the intestinal contents pass slowly through the large intestines with absorption of fluid and excretion of calcium and magnesium salts. These minerals unite with fatty acids to form the typical fat-soap-clay-coloured constipated stools characteristic of protein milk feeding, and it is at this point that dextrin-maltose should be added to the food."

"The majority of the cases were kept on protein milk for a period varying from three to four weeks, and, in many instances, contrary to the usual opinion, we were able to keep the children on protein milk plus starch and dextrin-maltose, sufficient for their caloric needs for a period of several months, in each instance accompanied by a substantial gain in weight and normal increase in vigor and tissue turgor with comparative freedom from digestive symptoms."—*A. Brown and I. P. MacLachlan: Protein milk powder, Canad. M. A. J., 9:528-537, June, 1919.*

1920

"There are three sugars commonly employed in infant feeding: (1) malt sugar or dextrin-maltose, (2) cane sugar, and (3) milk sugar. Malt sugar is the most easily digested and assimilated, cane sugar next and sugar of milk the least so."—*L. O. Frech: The caloric method of artificial feeding in normal babies, Illinois M. J. 38:484-488, Dec. 1920.*

1920

Regarding treatment in disturbed metabolic balance in infants, "The one carbohydrate which seems to give the most satisfactory results in these cases is malt sugar."—*C. H. Seybert: Disturbed metabolic balance in infancy, Hahnemann, Monthly, pp. 379-382, June, 1920.*

1921

"Next to woman's milk is cow's milk in simple modification with water and sugar in proper proportions and amount according to the age of the child. Milk Sugar is the most expensive and least satisfactory sugar. Dextrin-Maltose is the best sugar."—*A. A. Shawkey: Infant foods and infant feeding, West Virginia M. J. 15:284-287, Feb. 1921.*

1921

With reference to hypotrophy, "In mild cases, the addition of dextrin-maltose instead of cane or milk sugar may be sufficient to obtain a gain in weight."—*C. Herrman: The treatment of nutritional disorders in artificially fed infants, New York M. J. 114:158-160, Aug. 1921.*

1921

"Maltose and dextrin compounds are acceptable to the infant's digestion in relatively larger quantities. They are not as sweet as cane sugar. They are of practical value when larger amounts of cane sugar are not well borne."

"The so-called 'Mead's Dextrin maltose with Potassium Bicarbonate' is laxative, and in the presence of a stationary weight may be given in larger amounts."—*F. W. Fergusson: A method for the modification of cow's milk, Journal-Lancet, 41:628-629, Dec. 1, 1921.*

1921

For cases of fermentative diarrhea, "... the ideal plan of treatment would be to give a food which is low in sugar (the food which that group of organisms thrive on) and high in protein. Calcium caseinate milk accomplishes this purpose. In our series of cases, we found it was necessary to use the casein calcium for from 5-8 days; we then stopped it and added dextrin-maltose to the formula."—*A. G. DeSanctis and L. V. Paider: The value of calcium caseinate milk in fermentative diarrhea, Arch. Pediat. 38:233-236, April, 1921.*

1922

In the treatment of diarrhea, "The sugar is added gradually as conditions admit, some sugar other than milk sugar or cane sugar being used, preferably dextrin and maltose."—*H. E. Small: Diarrhoea in bottle-fed infants, J. Maine M. A. 12:154-158, Jan. 1922.*

1922

"The use of other soluble carbohydrates other than lactose for milk modifications are very good. Some believe the addition of dextrose or dextrin-maltose makes the casein curd softer and easier to digest. This is questioned, but all agree that in cases of malnutrition, where the patient is intolerant to lactose and cannot get the benefit needed from the fat in the diet that the dextrin-maltose is invaluable as it is the easiest sugar to digest, and can be immediately used for energy production without undergoing further change."—*E. G. Padfield: Remarks on infant feeding, J. Kansas M. S. 22:97-101, April, 1922.*

Continued down to 1934

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